[Company Name]

Authorization of Use and Disclosure of Protected Health Information

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1. Information to Be Used or Disclosed

The information covered by this authorization includes:

_____

_____

_____

2. Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

_____
Name of person/organization

_____
Name of person/organization

_____
Name of person/organization

3. Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

_____
Name of person/organization

_____
Name of person/organization

_____
Name of person/organization

4. Purpose of the Use or Disclosure

The information covered by this authorization is being used or disclosed for the following purpose(s):

_____

_____

_____

5. Expiration Date of Authorization

This authorization is effective through __/__/____ unless revoked or terminated by the patient or patient's personal representative.

6. Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to [Company Name]. You should contact the Privacy Officer to terminate this authorization.

7. Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to whom it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient